

Procedure	<b>Title:</b> <b>Self-pay Billing &amp; A/R Management</b>		
<input checked="" type="checkbox"/> Saint Francis Hospital and Medical Center <input checked="" type="checkbox"/> Mount Sinai Rehabilitation Hospital <input type="checkbox"/> Saint Francis Medical Group, Inc. <input type="checkbox"/> Saint Francis <i>Care</i> Medical Group, P.C. <input type="checkbox"/> Asylum Hill Family Medicine Center, Inc. <input type="checkbox"/> Saint Francis Behavioral Health Group, P.C.	<b>Proponent Department</b>  <b>DEPARTMENT BUSINESS OFFICE</b>	<b>Number</b>  	<b>Level</b> <input type="checkbox"/> System <input type="checkbox"/> Division <input checked="" type="checkbox"/> Department
	<b>Category</b> <input checked="" type="checkbox"/> Administrative <input type="checkbox"/> Clinical <input type="checkbox"/> HR <input type="checkbox"/> EOC	<b>Published Date</b>  July 1, 2011	<b>Review Cycle</b> <input type="checkbox"/> 1 year <input checked="" type="checkbox"/> 3 years

**PURPOSE:**

It is the policy of Saint Francis Hospital & Medical Center that all patients who have received services and that have outstanding financial obligations are given fair and objective opportunities to satisfy these responsibilities. To that end, Saint Francis Hospital commits to the following:

- All patients/patient guarantors shall receive a complete and patient statement detailing encounter specific information including dates of service, summary of charges, discounts applied, and amounts owed.
- Patients/patient guarantors will be properly informed of the various options available to satisfy their outstanding financial obligation(s) including assistance through the state of Connecticut's Medicaid Assistance Program as well as through St. Francis Hospital's internal financial relief program, and recurring payment plan guidelines.
- Patients/patient guarantors will be given a maximum of 120 days to resolve or set up a payment plan to satisfy an outstanding financial obligation before the account is eligible for bad debt.
- Patients/patient guarantors will be treated with respect and compassion in accordance with the Saint Francis Hospital & Medical Center mission.

**SCOPE:**

This procedure applies to the Business Office-Patient Accounting Department.

**PROCEDURE: Self-Pay Billing: Execution of the Self Pay Dunning Cycle**

All patient encounters for which the patient or the patient's guarantor are financially responsible for the unpaid balance, are inherently held by the billing application for the current lag day determine by the billing process to ensure all necessary charges, codes, and activity has been completed prior to submission. Upon expiration of this lag period, three concurrent processes are executed. First, the account balance associated with the patient encounter is moved from pre-receivable status to active accounts receivable status in the hospital's billing and accounts receivable system. Second, a patient statement displaying both total charges and the outstanding balance after any discounts have been applied, is generated and mailed to the patient through a contracted agent. Finally, a file containing the billed inventory is electronically transferred to a contracted self-pay collection agents to initiate account resolution activities. These three events coincide with the execution of the self-pay dunning cycle. The dunning cycle defines the submission interval between patient statements (i.e. - datamailers) as well as the various messages included on those statements. Each datamailer in the dunning cycle includes a

specific message as to the delinquency status of the account. The dunning cycle can be reset to previously issued datamailer statements through one of two means: Business Office staff can manually reset the dunning cycle or a change in the encounter's financial class. Primary self-pay balances, or those balances for which there is no insurance coverage, will receive a series of four statements beginning at day five (from billing) and with dunning cycle statement message number one. Self-pay balances resulting from an insurance payment will receive a series of four statements beginning five days from the financial class change to self-pay and with dunning cycle statement message number one. A file containing the billed inventory is electronically transferred to a contracted self-pay collection agent to initiate account resolution activities after billing statement cycle 2.

The statement intervals for both are generated in 30 day intervals and the entire dunning cycle, assuming no interventions, lasts 120 days.

### **Self-pay A/R Management: Execution of Self-pay Collection Efforts**

Collection efforts on self pay claims are assigned to a contracted collection and customer service agent from the day of billing. Upon generation of the self-pay claim, the encounter's financial class assignment is changed to reflect the agent to which the account is being assigned. Effective: 3/28/2011 all claim inventory is assigned and sent to American Adjustment Bureau staff (financial class code 959 - SP day One - AAB, financial class code 954 - SP Mcare Day One - AAB).

The contracted agent receives daily billing files as self-pay claims are generated. The Contracted agent submits a daily acknowledgement file to the hospital to confirm receipt of the assigned inventory. The acknowledgement file is posted on the Self Pay folder in the business office shared drive to expedite reconciliation of the assigned inventory.

Follow-up and collection activities will commence within ten days of receipt of the referral. Accounts are continuously prioritized throughout their lifecycle according to balance and circumstance and run through a predictive dialer application/voice broadcasting system to establish initial contact with the patient/patient guarantor. Patients whose established phone number has a voice answering system are left pre-recorded messages indicating the nature of the call and requesting them to contact the St. Francis Billing & Customer Service Department at the appropriate toll-free number. All patients are given an option to speak with a live customer service representative during the initial contact. Follow-up call intervals through the dialer are accelerated during the early phases of the billing process but are also coordinated with the corresponding issuance of patient statements from the hospital's billing system and as defined by the self-pay dunning cycle. Patients who have occasion to speak with a customer service representative shall be greeted in a courteous and professional manner and with an intention to resolve the outstanding balance in a mutually beneficial manner. All patients shall be made aware of the various financial assistance options available to them including but not limited to assistance through the state of Connecticut's Medicaid Assistance program as well as St. Francis' internal financial relief program and recurring payment plan guidelines.

Documentation of real time follow up activity is entered directly into the hospital's billing and accounts receivable system and applied through a generic canned comment that collection staff will expand on to include as much content as deemed necessary to convey the patient interaction.

### **Self-pay Write-offs: Execution of Bad Debt Write-off Protocols**

If after 120 days from self-pay bill date, the account balance has not been resolved, the account becomes eligible for bad debt write-off. The financial class assignment is changed to reflect the corresponding assignment of the bad debt to one of two contracted collection agents. Effective 11/1/2011: claim inventory is split alphabetically with patient last names beginning with the letters A – MI being assigned to American Adjustment Bureau staff (financial class code 951 - American Adj Bur BD, financial class code 953 - BD Mcare SP - AAB) and the remainder of the alphabet MJ- Z being assigned to Nair & Levin staff (financial class code 920 - Nair & Levin BD, financial class code 972 - BD Mcare SP - N&L). The account balance is subsequently removed from the active accounts receivable and becomes part of the bad debt receivable. Any patient payments secured on this receivable are classified as recoveries to bad debt. Contracted agents will pursue recoveries of referred accounts for a period of 180 days and perform similar referral management and collection activities as described above. Upon culmination of the 180 day holding period, any unpaid balances will be returned to the hospital.

Accounts that are returned as uncollectible may be considered for secondary placement with a contracted collection agency EOS CCA. The appropriate returned transaction code is applied to the account and the financial class is changed to 931 EOS CCA bad debt 932 EOS CCA Med Bad Debt. An electronic inventory is sent to the collection agency to pursue accounts for an additional 180 days. Any unpaid balances will be returned to the hospital.

### **PROCEDURAL ELEMENTS:**

(Note: Readers of this policy and procedure document should be cognizant of the interchangeable terminology that is used to convey accountability, ownership, and overall responsibility to the tasks set forth. As such, St. Francis Hospital may be hereafter referred to as "the hospital" or "the facility". Collection agency staff may be hereafter referred to as "collection agent", or "collection staff", or "customer service agent", or "customer service staff").

**Discounting** - The hospital currently applies a discount of 45% on all self-pay claims at the time of billing with the exception of outpatient clinic services that are registered under the various sliding scale options available to the patients based on a formal financial evaluation of income and family size. The hospital's billing and accounts receivable system automatically discount the account at the time of bill generation. Any additional discounts are subject to the policies set forth in the *Administration of Financial Relief and Assistance* section of this document and the hospital's official policy on financial relief and assistance. Insured patients who become responsible for outstanding balances as a result of charges being applied to a deductible or due to a policy based co-pay are similarly eligible for these discounts. However, any such discount that is deemed appropriate based on an evaluation of income and household size must be allocated manually by collections and customer service staff.

1. **Processing Financial Relief Applications** - All self-pay patients shall be made aware of the facility's financial assistance policy as a method of satisfying their outstanding obligation. Collection and customer service staff shall communicate the potential availability of financial assistance as part of its telephone salutation scripts. Upon confirming that the patient may wish to apply for financial relief, the customer service agent shall perform an initial screening to determine eligibility.

The customer service agent can make a preliminary determination of eligibility and the amount of

financial assistance or recommend that a Medicaid application be filed and communicate such to the patient. The customer service agent is instructed to caveat this determination upon the completion of a formal financial relief application and the submission of required and qualified documentation to the hospital. Please refer to the full version of the facility's financial relief and assistance policy in Appendix E of this document.

**Processing Payment Plans** - All claims for which collection staff has established a recurring payment arrangement with the patient/patient guarantor will be placed into one of two financial class designations, SP Budgets - AAB BUDGET (financial class code 957) or SP Medicare Budgets – AAB MCARE (financial class code 967) for accounts that are assigned with the agency. These designations will receive an alternative self-pay dunning cycle from the time of placement and are exempt from any bad debt write-off protocols. All efforts should be made to establish payment plans that resolve an outstanding balance within a reasonable time period. Collection staff should utilize to the following guidelines as a tool when structuring time based payment arrangements. We accept payment arrangements as long as we receive a consistent payment every month. Once a payment is missed, the account will be considered in default and may be eligible for Bad Debt.

Outstanding Balance	Time Frame	Maximum Average Monthly Payment
Less than or equal to \$2,400.00	12 months	\$200.00
\$2,401.00 - \$4,800.00	24 months	\$200.00
Greater than \$4,800.00	Less than 36 months	Case Specific

Collection staff shall reset the dunning cycle in accordance with the procedure documented in Appendix B of this document for this exclusion code. If a contract is not returned, the account shall continue its procession through the general self-pay dunning cycle and subject to all protocols associated with such including bad debt write-off. Upon receipt of the contract, collection staff shall move the account into the aforementioned agency based budget financial class and document the established payment plan by notating the terms of the contract. Returned and signed contracts shall be scanned for storage and future reference. Payments are expected to be made every thirty days. Self-pay collection staff will review all accounts placed into the aforementioned financial class designations daily to ensure that accounts are not delinquent according to the terms set forth in the payment plan contract. Collection efforts starting at Day 15 through Day 60 are as followed:

Delinquent Budget Statement Cycle	Statement Notification	Collector Follow up
Day 15	1 <sup>st</sup> Late Notification	Minimum of one weekly phone call
Day 30	2 <sup>nd</sup> Late Notification	Minimum of one weekly phone call
Day 45	3 <sup>rd</sup> Final Notification	Minimum of two weekly phone call
		SFS Financial Class Change to 965 Budget to Bad Debt
		Reason Code 61 Eligible for Bad Debt.

Follow-up protocols for delinquent accounts call for a series of 3 statements and a minimum of one weekly phone contact. Contact efforts shall be documented in detail on the account. Should an account become delinquent at day 15, the first late notification statement is generated. If a payment is not received by day 30, a second late notification statement is generated. At 45 days past due, a third delinquent notification statement is generated. If a payment is still not received within 15 days, the account is manually reviewed for referral to bad debt. Collection staff should review the dunning history and account comments. The collection staff should return the account, by changing the financial class in the hospital's billing and accounts receivable system to 965 Budget to Bad Debt, reason code 61 Eligible for Bad Debt. The account is then subject to all protocols associated with the bad debt write-off.

***Processing Payments by Phone*** - St. Francis accepts all forms of payment including cash, check, all major credit cards (Visa, Mastercard, American Express, Discover), and money order and can also accommodate any other transfer of funds including wire transfer. Payments and payment information shall be accepted and encouraged by phone. Collection staff shall complete a payment information form. All necessary information shall be collected as determined by the form and the payment information shall be entered into the Saint Francis Care website for online payments. Denials for funds shall be securely returned to the originating collection agent for appropriate follow-up with the patient/patient guarantor.

***Processing Patient Refunds*** - Collection staff shall review credit balance reports on a regular basis to identify those accounts that are in a credit balance condition as a result of transaction activity. Payment and adjustment history on the account shall be reviewed to determine if the account has been truly overpaid or an appropriate adjustment is required. Upon confirming the legitimacy of the overpayment, collection staff will review the account history for the patient to determine if there are other outstanding balances to which the overpayment can be applied. If another account with an outstanding balance is available, collection staff shall escalate the account to the Self-pay Support Services Manager who will coordinate the transfer of the overpaid amount to the outstanding balance on the other account. Should the account be determined to be an overpayment and there are no other outstanding balances for which to apply the overpaid amount, then collection staff shall disposition the account with the appropriate return code at which point, the hospital's patient refund specialists shall process the refund to the patient within 60 days of identification.

***Processing Recovered Insurance Information*** - Prior to billing, all primary self-pay accounts will be run against the hospital's automated eligibility verification system to identify potential insurance coverage through Medicaid and Medicare. Should the inquiry yield valid third party insurance coverage, the hospital's benefit verification specialists will manually update such information in the hospital's billing and accounts receivable system and re-bill the account accordingly (prior to assignment to the respective agent). Once billed, patients will have the ability of submitting valid third party insurance coverage on the back of the statement stub or over the phone to a customer service representative. Coverage through the stated insurance will be verified through an appropriate eligibility verification medium, updated in the hospital's billing and accounts receivable system, and re-billed to the new payer of record accordingly. Collection staff shall disposition the account with return code 95000093 to close their responsibility to the account (Please refer to Appendix B for a complete list of policy specific exclusion and return codes).

***Processing Patient Inquiries/Complaints*** - The hospital has identified the following as the most common reasons that patients/patient guarantors will inquire and/or contest a bill. Such cases will be excluded from bad debt write-off protocols until the inquiry has been deemed resolved. Collection staff will be required to investigate the validity of the inquiry through the appropriate channels and render a formal determination back to the patient/patient guarantor within 30 days from the date of initial inquiry.

***Inquiries related to charges on the account – REFER TO SELF PAY MANAGER***

***Inquiries related to the accuracy of the date of service - REFER TO SELF PAY MANAGER***

***Inquiries related to being seen/being treated/leaving AMA - REFER TO SELFPAY MANAGER***

***Processing Special Guarantors*** - As part of the hospital's access management policy, service areas are instructed to identify special handling of accounts through registration. The following guarantors are used to identify these special circumstances. All such cases are registered with one of the following hospital addresses:

- 114 Woodland Street, Hartford Connecticut 06105
- 500 Bluehills Avenue, Hartford, Connecticut 06105
- 490 Bluehills Avenue, Hartford, Connecticut 06105

Bills for claims with these guarantors are filtered out by the hospital's statement vendor and reported back to the hospital for review and appropriate action (Note: Contracted agencies must exclude all such cases from any collection efforts until management review is completed). Collection staff shall disposition these claims with the appropriate return code upon applicable reprocessing. Collection staff shall apply a dunning cycle hold on all accounts deemed special guarantors until management review is complete and such determination is made that the patient/patient guarantor is in fact responsible for the outstanding balance.

***Cosmetic*** - Plastic surgery cases for which specific payment arrangements between the patient and the doctor are made need to be tracked to ensure proper payment posting and resolution of the difference between the total charge and the agreed upon payment. Collection staff is instructed to ensure that proper payment has been posted to the account by reviewing system documentation and verifying the nature of the agreement. In situations where there is no documented evidence of the agreement, collection staff shall contact the physician's office directly and request a written agreement/notification between doctor and patient be provided. Upon verifying such, the residual account balance is written off to the contractual allowance code of 97000357. Should the collection agent confirm that the patient/patient guarantor still owes a remaining balance, he/she shall release the dunning cycle statement hold so that the patient may continue to receive his/her notices indicating the remaining balance due. All other follow-up and collection activities apply.

***Risk Management*** - Cases for which Risk Management is the entered guarantor are forwarded to the Risk Management Office for review and the account is documented as such. If, upon review, the Risk Management office deems the hospital accountable for the case, it will notify the Business Office as such. The account will be documented in the hospital's billing and accounts receivable systems and written off to the appropriate administrative adjustment code of 97000064. Should the collection agent confirm that the hospital is not responsible for the balance and patient/patient guarantor still owes a remaining balance, he/she shall release the dunning cycle statement hold so that the patient may continue to receive his/her notices indicating the remaining balance due. All other follow-up and collection activities apply.

***Pulmonary Grant – Change Financial Class to Institutional***

***Occupational Health –Change Financial Class to Institutional***

***Homeless*** - Cases for which the patient has been confirmed as undomiciled at the time of service are documented by collection staff and the account balance shall be written off to the appropriate adjustment code of 97000037.

***Business Office Director*** - This guarantor is used as a mechanism to identify and review any other patient claims that may be of an extraordinarily sensitive nature.

***Processing Bad Addresses*** - Patient statements will include a return address corresponding to the contracted agent thus ensuring bad addresses are returned to the agent's dedicated P.O. Box for reprocessing. Collection staff will research address solutions and update the hospital's billing and accounts receivable system accordingly. Possible sources of address verification include the hospital's billing and accounts receivable system, eligibility verification applications, address verification technology, and the internet. Should collection staff be unable to secure a valid address the account will be dispositioned as a "bad address" returned to the hospital by changing the Financial Class to 913 (Bad Address/Efforts exhausted) Reason Code 61 Eligible for Bad debt where it will be written of as a bad debt.

***Pursuit of Legal Resolution to Outstanding Debts: REFER TO SELF PAY MANAGER***

***Excluding Accounts from Bad Debt Write-off*** - The hospital has identified the following circumstances as valid reasons for excluding an account from being written off to bad debt at the designated 120-day time frame. In order to prevent such accounts from being written off, collection staff will notify the Self Pay Manager who will place a hold on the dunning cycle statement counter so that they will remain on the active accounts receivable when automated bad debt write-offs are executed at the end of each month.

**REFERENCES:**

**CROSS REFERENCES:**

**APPROVED BY:** Policy requires Director approval.

Director(s): Sarah Alber  
/s/ Sarah Alber

Date:  
1/21/2012

**REPLACES:**

**June 1, 2007 procedure**

<p align="center">Policy</p>	<p><b>Title:</b> <b>FINANCIAL RELIEF FUNDS POLICY AND PROCEDURES</b></p>		
<input checked="" type="checkbox"/> Saint Francis Hospital and Medical Center <input checked="" type="checkbox"/> Mount Sinai Rehabilitation Hospital <input type="checkbox"/> Saint Francis Medical Group, Inc. <input type="checkbox"/> Saint Francis <i>Care</i> Medical Group, P.C. <input type="checkbox"/> Asylum Hill Family Medicine Center, Inc. <input type="checkbox"/> Saint Francis Behavioral Health Group, P.C.	<p><b><u>Proponent Department</u></b></p> <p align="center">DEPARTMENT OF BUSINESS OFFICE</p>	<p><b><u>Number</u></b></p>	<p><b><u>Level</u></b></p> <p><input type="checkbox"/> System  <input type="checkbox"/> Division  <input checked="" type="checkbox"/> Department</p>
	<p><b><u>Category</u></b></p> <p><input checked="" type="checkbox"/> Administrative  <input type="checkbox"/> Clinical  <input type="checkbox"/> HR  <input type="checkbox"/> EOC</p>	<p><b><u>Published Date</u></b></p> <p align="center">April 1, 2011</p>	<p><b><u>Review Cycle</u></b></p> <p><input checked="" type="checkbox"/> 1 year  <input type="checkbox"/> 3 years</p>

**PURPOSE:**

It is the policy of Saint Francis Hospital and Medical Center & The Rehabilitation Hospital of CT to ensure a socially just practice for billing patients receiving care at any of its facilities. Financial Relief is a financial assistance program offered by Saint Francis Hospital and Medical Center and The Rehabilitation Hospital of CT for the benefit of our uninsured or underinsured patients who are unable to pay for their care. This policy relates to all medically necessary inpatient, outpatient, clinic, and emergency department visits. Excluded from this policy are cosmetic procedures and private room differentials.

**SCOPE:**

This policy reflects our commitment to individual human dignity with special concern for poor and vulnerable persons.

**POLICY:**

Effective January 1, 2012: All self pay patients are given a 45% discount off of the published charges. For patients in need of additional assistance, the completion of the financial relief application is required for a determination to be made for the applicable Free Bed funding and/or hospital financial relief.

**Application for Financial Relief**

1. Application may be obtained from the appropriate hospital personnel: Financial Counselors, Collection Representatives, and Telephone Representatives.
2. The completed and signed application must be returned to the Business Office with the following requested documentation, in the return envelope provided.
  - a. family size
  - b. income verification three most current pay stubs; previous year's tax return or a letter from an employer or government agency which verifies income).
  - c. Or active Medicaid eligibility screen print that indicates full Medicaid coverage(for spend downs or services prior to Medicaid coverage)

If any of the above mentioned documents are not received the application will be denied.

3. An application for State Medical Assistance (Medicaid) must be completed for those patients with verified income below 100% poverty. If the patient is ineligible for Medicaid they will be offered hospital financial relief based on our sliding fee scale. If a patient is approved for Medicaid, they will automatically be eligible for financial assistance. Bills applied towards a

patient's spend down which results in active coverage will be adjusted off to the financial relief allowance code 97000384.

4. Eligibility is determined on income and total medical bill obligations.
  - a. Income eligibility is based on the federal poverty guidelines. Patients with income levels under 150% of the federal poverty guidelines who are ineligible for State Medical Assistance will receive 100% financial relief. Sliding scale arrangements are available for patients with income under 250% of the federal guidelines. Discounts range from 45% to 100% (full eligibility).
  - b. An assessment is made on the patient's total medical bill obligations. If the patient responsibility is greater than 50% of their total annual income, they are eligible for additional discounts.
    - i. Effective 1/1/12: A self pay patient will be entitled to the above stated 45% discount off of charges along with an additional 21% financial relief resulting in a total of 58% discount off of hospital charges.
    - ii. A patient with insurance coverage who has medical bill obligations after insurance payment that is 50% greater than their total income will be eligible for a flat 20% discount.
5. The Self pay Manager and appropriate personnel determine eligibility within 30 days of receipt of the completed application. Any patient granted partial assistance will be asked to establish an agreed upon payment plan for the balance within thirty days of approval.

**ADJUSTMENTS GREATER THAN \$1,000.00 ARE SUBJECT TO APPROVALS AS FOLLOWS:**

\$5,000-\$24,999 requires a Manager's approval

\$25,000-\$50,000 requires the Director of Patient Financial Services approval

>\$50,000 requires the VP of Revenue Management approval

After obtaining approval, staff will apply adjustment.

6. Assessment for free bed funding is completed as part of the financial assessment.

**To be Noted**

- For all financial relief cases where the patient or spouse is self employed, the gross income will be used after the business expenses are deducted. This information is obtained from the "Profit or Loss Statement" or income reported on the 1040 or 1040A.
- Patients seeking financial relief who are under sponsorship of relatives are determined eligible if the sponsor provides the appropriate income/household documentation. Eligibility is determined on income.

**REFERENCES:**

**CROSS REFERENCES:**

**APPROVED BY:** Policy requires Director and Vice President approval.

Director(s): Sarah Alber  
/s/ Sarah Alber

Date:  
1/23/2011

Vice President(s): Nicole Schultz

Date:  
1/23/11

**REPLACES:**

**REVISED DATE: 10/1/03; 3/15/04;9/01/04; 11/01/04; 03/07/05; 10/01/05; 10/1/06; 3/1/07;  
4/11/08; 5/22/09, 7/1/2011, 1/23/2012**

**Saint Francis Hospital and Medical Center**  
**Community Assistance Program**  
**Eligibility Criteria On or After 01/01/2012**  
2011 Poverty Guidelines

FAMILY SIZE	ANNUAL GROSS INCOME		
	POVERTY	200%	250%
1	10,890	21,780	27,225
2	14,710	29,420	36,775
3	18,530	37,060	46,325
4	22,350	44,700	55,875
5	26,170	52,340	65,425
6	29,990	59,980	74,975
7	33,810	67,620	84,525
8	37,630	75,260	94,075
9	41,450	82,900	103,625
10	45,270	90,540	113,175

SLIDING SCALE

Rate    A = PAT. OWES    55%  
            B = PAT. OWES    42%  
            C = FULL ASSIST 100%

WEEKLY GROSS INCOME		MONTHLY GROSS INCOME		ANNUAL INCOME	SLIDING SCALE FAMILY SIZE									
					1	2	3	4	5	6	7	8	9	10
0 -	418	0 -	1,815	21,780	C	C	C	C	C	C	C	C	C	C
419 -	522	1,816 -	2,269	27,225	B	C	C	C	C	C	C	C	C	C
523 -	564	2,270 -	2,452	29,420	A	C	C	C	C	C	C	C	C	C
565 -	711	2,453 -	3,088	37,060	A	B	C	C	C	C	C	C	C	C
712 -	857	3,089 -	3,725	44,700	A	A	B	C	C	C	C	C	C	C
858 -	888	3,726 -	3,860	46,325	A	A	B	B	C	C	C	C	C	C
889 -	1,004	3,861 -	4,362	52,340	A	A	A	B	C	C	C	C	C	C
1,005 -	1,072	4,363 -	4,656	55,875	A	A	A	B	B	C	C	C	C	C
1,073 -	1,150	4,657 -	4,998	59,980	A	A	A	A	B	C	C	C	C	C
1,151 -	1,255	4,999 -	5,452	65,425	A	A	A	A	B	B	C	C	C	C
1,256 -	1,297	5,453 -	5,635	67,620	A	A	A	A	A	B	C	C	C	C
1,298 -	1,443	5,636 -	6,272	75,260	A	A	A	A	A	A	B	C	C	C
1,444 -	1,590	6,273 -	6,908	82,900	A	A	A	A	A	A	B	B	C	C
1,591 -	1,621	6,909 -	7,044	84,525	A	A	A	A	A	A	B	B	B	C
1,622 -	1,736	7,045 -	7,545	90,540	A	A	A	A	A	A	A	B	B	C
1,737 -	1,804	7,546 -	7,840	94,075	A	A	A	A	A	A	A	B	B	B
1,805 -	1,987	7,841 -	8,635	103,625	A	A	A	A	A	A	A	A	B	B
1,988 -	2,171	8,636 -	9,431	113,175	A	A	A	A	A	A	A	A	A	B